

HEALTH INSURANCE

A guide to your rights and choices



Dear Fellow Montanan,

I am pleased to provide you with a copy of
"Health Insurance: A Guide to your Rights and Choices."

Health insurance is an expensive purchase and there are many factors to consider when choosing a policy. This guide will help you ask the right questions, avoid some common mistakes and make sure you get coverage that is appropriate for your needs and your budget.



*One of my goals as
Commissioner of
Securities and Insurance
is to help you to be an
informed buyer.*

On the following pages, we will explain employer, group and individual health insurance. We'll also look at factors that influence your insurance rates and some discounts insurers commonly offer. And finally, we'll cover your rights and options when you have a problem with your insurance.

This guide is not a replacement for the detailed information found in your policy or benefits booklet. I encourage you to always keep a copy of your plan and take time to familiarize yourself with your benefits *before* you have a claim.

Please contact my office if you have questions or need additional assistance. Our knowledgeable staff is here to help you with a wide range of insurance issues. Call our consumer assistance hotline at 1-800-332-6148 or visit our website at www.csi.mt.gov for more information.

Sincerely,

A handwritten signature in dark ink that reads "Monica J. Lindeen".

Monica J. Lindeen
Commissioner of Securities & Insurance
Montana State Auditor

HEALTH INSURANCE: A Guide to your Rights and Choices

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INTRODUCTION

Anyone who has visited the doctor's office recently knows how expensive medical services can be. Most people buy health insurance to help pay for everything from routine checkups and prescription drugs to cancer treatments and potentially life-saving surgery.

Health insurance options span a wide range of benefits and costs. So how do you get the coverage you need at the best price?

This guide will help identify the various types of health insurance and provide you with enough information to purchase the coverage you need.

Key factors to consider when buying insurance include:

- ◆ **Coverage:** Will the plan meet the health needs of you and any dependents covered by your policy?
- ◆ **Cost:** How much you can afford to pay for premiums and out-of-pocket expenses before the insurance company pays;
- ◆ **Convenience:** Will you have easy access to medical providers who accept your insurance?

HOW to GET HEALTH INSURANCE

Most people get health insurance through group plans offered by their employers. The cost of these plans is usually shared between the employer and the employee through payroll deductions. If your employer does not offer group coverage, you may be able to buy a policy for yourself and your family on the individual market.

Group Health Insurance

At Work

Employers are not required to provide health insurance for employees. However, if an employer chooses to offer health coverage, the policy must be available to all eligible employees. The employer pays a portion of the cost and the employee pays the balance. Advantages to employer group insurance are that insurers may not reject people for group coverage and must cover pre-existing conditions (sometimes only after a 12-month exclusion period). Also, you have better access to a new insurance plan if you leave group coverage through one of several continuing coverage options. The disadvantages to group coverage are that your employer determines the deductible and you lose coverage if your job ends or your employer decides not to renew the policy. Often, employees are not eligible for health benefits until they have worked for a specified period of time (a “waiting period”). New employees may need to maintain their previous insurance policy until they are eligible to enroll. The spouse and dependents of an employee generally are eligible for coverage with a group policy, usually at the employee's expense.

Club and Association Plans

Some fraternal and professional organizations, associations and clubs offer group health insurance to members. Unless offered by your employer, this coverage may not be available if you have certain health conditions. To find out whether an organization offers health insurance to its members, contact the organization's member services representative.

Pre-existing Conditions in Group Coverage

A group health insurance policy may not exclude coverage for a pre-existing condition unless medical advice, diagnosis, care, or treatment were recommended or received in the six months prior to the enrollment date. Coverage for the pre-existing condition may not be excluded for more than 12 months. Pregnancy is NOT considered a pre-existing condition in group health insurance. A pre-existing condition exclusion period may be waived if you had prior comprehensive medical coverage within 63 days of becoming eligible for your new employer coverage. Plans may not impose any exclusion of benefits (including denial of coverage) or limit coverage based upon a pre-existing condition for anyone under age 19.

Individual Health Insurance

Individual health insurance covers one person or all members of a family under one policy. People generally buy individual health insurance policies because they do not have access to employer group insurance. Individual health policies also are used to supplement Medicare and to bridge a gap in coverage between jobs that offer group health insurance.

Pre-existing Conditions in Individual Coverage

Coverage for a pre-existing condition may not be excluded under an individual health insurance contract unless medical advice, diagnosis, care, or treatment were recommended or received in the three years prior to the coverage enrollment date. The condition cannot be excluded for more than 12 months. This waiting period may be waived for the time period you had qualifying previous coverage if you applied for a new plan within 30 days of ending your last coverage. Individual health plans (except for grandfathered individual health plans) may not impose any exclusion of benefits, deny coverage, or limit coverage based upon a pre-existing condition for anyone under age 19.

Individual health insurance policies may also exclude coverage for certain pre-existing conditions indefinitely. This is

called an “exclusionary rider.” Exclusionary riders may not be placed on children under age 19 (except for grandfathered individual health plans.)

Is your Family Protected?

In general, all health insurance policies, certificates and membership contracts must contain benefits and policy provisions required by Montana and federal law. You should ask your agent or company if the policy that you have or the one you are considering meets these requirements or call the CSI (1-800-332-6148). Your insurance contract must have been approved by the CSI before it was issued to you.

SHOPPING TIP: Know what you have before you buy.

- Review all of your insurance coverage every two years to be certain it is sufficient to meet your needs.
- Keep up-to-date information on medical insurance, disability benefits and sick leave benefits provided by your employer.
- If you want to have your spouse and children covered under your policy, make sure that you have properly signed up for the coverage.
- If there are changes in circumstances, such as the birth of a child, a child reaching age 26, or marriage, separation or divorce between you and your spouse, check on the child and spouse's continued eligibility and rights to other kinds of continuing coverage such as COBRA, portability or conversion.
- Be sure you have major medical health insurance before you consider buying other types of “supplemental” health insurance.
- Maternity coverage will provide certain benefits for the mother.
- Newborn coverage will cover an infant for the first 31 days, but then that infant must be added to the policy and premiums must be paid. Acceptance is guaranteed for all types of coverage.
- You can reduce your health insurance monthly premiums by choosing plans with higher deductibles, coinsurance and co-payments.

STAYING INSURED

Getting health insurance through an employer can make insurance more affordable, but it also ties coverage to employment. If you lose your job, you may lose your coverage if you don't take steps to stay insured. Maintaining coverage not only protects you from unexpected medical costs, but also allows you to join a future employer's plan without pre-existing condition exclusions.

COBRA Coverage

If you lose your employer coverage, you may qualify for COBRA coverage. To qualify for COBRA coverage you must meet three criteria:

1. Your employer must have 20 or more employees.
2. You must be covered under the employer's group health plan as an employee, spouse or dependent.
3. You must have a qualifying event, such as termination of employment, a reduction in work hours, divorce from or the death of a covered employee which would cause you to lose your group health coverage, or a dependent loses eligibility because of age.

When you terminate employment, you are allowed to retain the group coverage for you and your family for up to 18 months. However, certain disabled people can continue coverage for up to 29 months, and dependents are eligible for up to 36 months of COBRA continuation coverage, depending on their qualifying event. You pay the full premium, including the amount previously paid by the employer, plus a 2 percent administrative fee charged by the insurer.

Premiums must be paid in a timely manner. Your policy may terminate if payments are received late. Check your employee booklet or policy for the specific requirements and terms of cancellation. You must sign-up for COBRA within 60 days of the date the COBRA election notice was issued.

After you exhaust your COBRA coverage, portability coverage is your next option as long as you apply within 63 days of the termination of COBRA coverage.

Portability Coverage

The Health Insurance Portability and Accountability Act (HIPAA) guarantees individual coverage for people leaving employer-sponsored group, church or government plans if you've had continuous coverage during the previous 18 months through any combination of plans.

Portability plans are available through the Montana Comprehensive Health Association (MCHA). They are often less expensive than conversion plans. Portability coverage is comprehensive major medical coverage offering a \$1000 to a \$10,000 deductible. There is no exclusion period for pre-existing conditions. You need to apply for coverage with the portability plan within 63 days of the termination of your group coverage or COBRA coverage. You must exhaust your COBRA coverage before you are eligible for portability coverage. The premium can be up to 150% of average market rate.

Portability plans have certain eligibility requirements. Check with the MCHA to determine whether you qualify. Contact the administrator at:

Montana Comprehensive Health Assoc.
404 Fuller Ave.
P.O. Box 4309
Helena, MT 59604-4309
1-800-447-7828, ext. 2128
www.mthealth.org

Conversion Coverage

You may convert from a group policy to an individual policy if you have had insurance for at least three months. You must apply within 31 days of termination of group coverage or employment. The company must offer a choice of any group or individual health plan it customarily sells. It also must offer you a conversion plan with the same coverage as the lowest-cost basic group health plan it sells to small employers.

Your conversion policy cannot impose a new pre-existing condition exclusion period.

Conversion policy premiums may be much more expensive than your former group plan premiums, but they cannot be more than twice as high as the average premium charged by the insurer for that health plan.

High Risk Pool Coverage

If you do not qualify for portability coverage, you may qualify for the traditional high risk pool coverage administered through the MCHA. If you have been rejected for individual health insurance or have a high risk medical condition, you may be eligible for the high risk pool, which may cost as much as 150% of the average market rate but may be less. If you meet the eligibility requirements, you cannot be declined.

There may be a pre-existing condition exclusion for up to 12 months. Rates are based on age and are published at www.mthealth.org

Montana Affordable Care Plan

The Montana Affordable Care Plan is another type of high risk pool that is funded by the federal government until 2014. You must have a high risk condition and have been uninsured for the previous six months. Because of the federal subsidy, the rates for this coverage are set at the average market rate and all pre-existing conditions are covered.



SHOPPING TIP: Tell the truth about your health.

If you intentionally misrepresent a material fact when giving the company your complete health history, your policy can be canceled retroactively and/or benefits can be denied.

When applying for health insurance coverage, remember to:

- Review the application for accuracy;
- Make sure your medical history is complete.

REQUIRED BENEFITS under MONTANA and FEDERAL LAW

The following benefits must be included in most or all insurance policies and certificates issued in Montana.

Please note: There are many self-funded plans under which Montana residents may have coverage. These plans (other than self-funded government plans) are subject to the federal Employee Retirement Income Security Act (ERISA) and are not subject to compliance with state required benefits. Self-funded health plans must comply with most minimum requirements of federal law.

The Patient Protection and Affordable Care Act of 2010 (ACA) provides additional protections for health insurance consumers, some of which went into effect on September 23, 2010 and are noted here. Some of these protections do not apply to “grandfathered” health plans. Simply put, a grandfathered health plan was issued prior to March 23, 2010. However, other rules also affect grandfathered status. If your plan is grandfathered, you should have received a notice from your health insurer. If you are unsure, contact your health insurer or call the CSI at 1-800-332-6148.

Phenylketonuria Treatment

Some individuals are born unable to metabolize the amino acid phenylalanine (PKU). These people cannot eat protein in the usual manner and require treatment. Under Montana law, insurers must cover the cost of treatment and services for phenylketonurics, subject to cost-sharing required by the particular insurance contract.

Diabetic Treatment

Coverage for diabetic treatment, including medically necessary equipment and supplies, and diabetic education is required for all group health plans, but not individual plans.

Coverage for Autism Spectrum Disorders

All health insurance contracts must provide coverage for autism spectrum disorders, including medically necessary habilitative and rehabilitative care. Annual maximums for certain types of treatments may apply.

Mental Illness, Alcoholism and Drug Addiction

An insurance company must cover medically necessary charges related to mental illness, alcoholism and drug addiction for people insured under group policies. Some coverage limits may apply.

Large employers with more than 50 employees must cover all mental illness and chemical dependency treatment to the same extent as other physical illness generally.

All health plans, including individual health insurance, must cover severe mental illness in the same manner as other physical illness generally. Severe mental illness includes a diagnosis of: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, and autism.

Access to Obstetricians, Gynecologists and Pediatricians

Health plans must allow patients to see an obstetrician or gynecologist without a referral. In addition, OB/GYNs must be allowed to participate as primary care

physicians. Primary care physicians may provide initial or primary care, maintain the continuity of care and make referrals for specialist care for their patients. Pediatricians may also act as primary care physicians.

Maternity Coverage

Maternity costs must be covered under all health insurance plans issued in Montana.

Minimum Hospitalization after Childbirth

All health insurance must provide coverage for at least 48 hours of inpatient hospital care following a vaginal delivery and at least 96 hours of inpatient hospital care following delivery by Cesarean section for a mother and newborn infant.

Newborns

Newborns must be covered by health insurance from birth for 31 days if one or both parents are covered under the policy or certificate. Parents have 31 days to notify the insurance company of the birth and pay any additional premiums in order to continue coverage for that child. Acceptance is guaranteed. All pre-existing conditions must be covered.



Well Child Care

Health insurance must cover well child care through the age of seven years without imposing the deductible based upon a schedule of examinations and immunizations. If you have a “non-grandfathered” health plan, all federally-recognized preventive care for children of any age, including immunizations,

is covered with no cost-sharing. Certain exceptions apply (example: out-of-network providers).

Mammograms

Insurance must pay \$70, or the actual cost if less than \$70, for mammograms starting at age 35 and based upon a schedule thereafter. However, if your health plan is “non-grandfathered,” the plan must pay for mammograms in-full. In-network providers must be used.

Post-Mastectomy Care

Health insurance must provide coverage for hospital inpatient care for a period of time determined by the attending physician to be medically necessary following mastectomy, lumpectomy or lymph node dissection for the treatment of breast cancer.

Post-Mastectomy Reconstructive Surgery

Health insurance must provide coverage for reconstructive surgery that follows a mastectomy for breast cancer. The cost of prostheses must be covered. Any plan providing outpatient x-ray or radiation therapy must cover outpatient chemotherapy following surgical procedures in connection with the treatment of breast cancer.

Freedom of Choice of Practitioners

Health insurance must provide freedom of choice and pay for covered services of any licensed physicians, certified physician assistants, dentists, osteopaths, chiropractors, optometrists, podiatrists, psychologists, licensed social workers, licensed professional counselors, acupuncturists, naturopathic physicians, and nurse specialists, all acting within the scope of their licenses. Health services corporations such as Blue Cross Blue Shield of Montana and HMOs are exempt from this statute, except for certain dentist services, chiropractic services, nurse specialists, naturopathic physicians and physical therapists.

Adopted Children

Health insurance companies must allow the addition of adopted children to any group or individual policy as dependents from the time of placement in the family, without pre-existing conditions. Acceptance is guaranteed.

Adult Dependent Coverage

Plans that provide dependent coverage must extend coverage to adult children up to age 26. Carriers are not required to cover children of adult dependents. Coverage of adult dependents up to age 26 must be offered, regardless of the marital status, student status, financial dependency, or employment status of that dependent.

Continuation of Coverage for Handicapped Dependents

If an insurance contract covers dependents, coverage must continue beyond the age of 26 for handicapped dependents. You must notify the insurance company of the disability.

Individual Family Disability Insurance Continuity of Coverage

A family member covered under an individual family medical insurance policy is entitled to remain covered upon the death of the named insured, or if a marriage annulment or divorce occurs.

Continuation of Benefits to Dependents

Group policies may continue benefits to family members and dependents after the death of a person in the group.

Continuation of Group Coverage after Reduction in Work

If a person covered by a group policy receives a reduction in work hours below the minimum time required to qualify for membership in the group, he/she may

receive continued coverage at the same premium rate for one year following the work reduction.

Conversion of Entitlement of Insured Family

Upon the death of an individual receiving employer-sponsored health insurance, conversion privileges must be given to a surviving spouse and dependent children.

Preventive Services may be covered under the ACA

Unless you have a plan that is grandfathered, health plans must cover the following preventive services with no out-of-pocket cost when provided by a health care professional in your company’s network:

- Services recommended by the U.S. Preventative Services Task Force, like colonoscopies and cholesterol screenings;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control;
- Preventive care and screening for infants, children and adolescents supported by the Health Resources and Services Administration;
- Preventive care and screening for women supported by the Health Resources and Service Administration.

Lifetime Limits

Under federal law, lifetime limits on essential health benefits are no longer allowed.

Annual Limits

Under federal law, annual limits on essential health benefits in non-grandfathered health plans are eliminated over time:

- \$750,000 per year until September 23, 2011;
- \$1.25 million per year until September 23, 2012;
- \$2 million per year until December 31, 2013;
- Beginning January 1, 2014, annual limits on essential health benefits are not allowed.

EXCLUSIONS

All health insurance companies have a list of benefits they will not cover.

The longer the list, the less coverage the policy provides. Policies with fewer exclusions may be more expensive. Before enrolling, read the list of exclusions and make sure you understand what the policy covers.

In addition to excluding pre-existing conditions, health insurance policies often exclude illness or injury resulting from:

- War or military service;
- Aviation (in certain circumstances);
- Illness or injury covered under workers’ compensation;
- Intoxicants or narcotics.

WHAT to LOOK for in a HEALTH INSURANCE COMPANY

Cost is just one factor to consider when reviewing policies. You should also look for a company that is financially stable and that pays your claims promptly, fairly, efficiently and courteously.

When you shop for insurance, ask your friends and relatives what kind of service their companies and the agents who sell their insurance have given them. If you have questions about a company or an agent, contact the CSI at 1-800-332-6148. The CSI cannot make specific recommendations, but staff can verify whether a company or agent is licensed in Montana.

Your insurance agent should be:

- Reliable, helpful and able to answer any questions you may have about a policy, now and in the future;
- Available to assist you with reviewing your coverage;
- Able to help you with claims disputes.

Most agents are honest, but remember:

- An agent cannot change the contents of a policy; only the insurance company can. If the agent fills out the application for you, read it carefully and completely before signing it. Check for accuracy.



- Never make a check or money order payable to the agent or agency: make it payable to the insurance company. Do not pay in cash; always get a receipt.
- If it sounds too good to be true, it probably is. If you are being offered extensive coverage for a very low premium, it may not be a legitimate plan.

Researching a Company

Before you buy health insurance, get to know the company selling the plan.

The CSI can provide the following important information about a company:

- Are the company and the agent licensed to sell insurance in Montana?
- Is the company financially stable?
- Does the company have a high number of consumer complaints?

COLLECTING YOUR BENEFITS

Submit your claim properly

- Find out if your provider submits the claim for you or if you need to do it.
- If you need to submit the claim, review the information to be sure it is complete and accurate.
- File it as soon as you get the bill from the provider. Generally you must tell the company of your claim in writing within 20 days of the loss or as soon as is reasonably possible. You also must give written proof of the loss to the company within 90 days of the loss or as soon as is reasonably possible. However, most claims are now submitted electronically to the insurer by the healthcare provider.
- Keep copies of correspondence and record the date you send it.
- The insurer must pay claims within 30 days, with some exceptions.

KNOW YOUR HEALTH CARE RIGHTS

Insurance companies may not cancel coverage retroactively (known as rescission) except in cases of fraud or intentional misrepresentation of a material fact. An insurer must provide at least 30 days advance written notice to each participant who would be affected prior to rescinding coverage. A rescission decision may be appealed.

Insurance companies usually are not allowed to discriminate against consumers regarding rates or the kinds of coverage offered.

Claims must be paid fairly and promptly.

Consumers have a right of access to certain information collected by insurance companies, including information on decisions to terminate or refuse coverage.

Other information your insurer must provide (as written guidelines):

- Covered benefits, services, co-pays and co-insurance amounts;
- Participating providers, network and service area restrictions;
- Referrals to specialists;
- Where to go for emergency care;
- Preauthorization requirements;
- How to choose and change primary-care providers;
- General prescription drug formulary guidelines;
- How enrollees will be notified of changes in benefits;
- How enrollees will be notified of changes in physician availability and how to obtain assistance.
- Language services available to non-English speakers.

SHOPPING TIP: Find out why your insurer is raising rates.

People in every state can now go to www.HealthCare.gov to access consumer-friendly disclosure information explaining insurers' proposed premium increases that are 10 percent or higher than last year's rates. You will see a summary of the key factors driving rate increases and an explanation provided by insurance companies for why the proposed increase is needed. You also have the ability to comment on large proposed rate increases.

SHOPPING TIPS

When shopping for an individual health insurance policy it is important to make sure you are buying the health care plan that meets your needs and your budget. Make a list of your needs to compare with the benefits offered by a plan you are considering and compare plans to find out why one is less expensive than another.

Here are some questions to ask when shopping for health insurance:

Questions about Coverage

What does the plan pay for?

What does the plan exclude?

What are the pre-existing medical condition limits?

Will the plan pay for substance abuse, organ transplants, vision care, dental care, infertility treatment or durable medical equipment?

Will the plan pay for your prescriptions?

How much mental health coverage does the plan offer?

Will the plan pay for long-term physical therapy?

Questions about Premiums

How much will rates increase as you age?

How much do you have to pay when you receive health care services?

- Copayments?
- Coinsurance?
- Deductibles?

Are there any limits to how much you must pay for health care services you receive (out-of-pocket maximums)?

Does the deductible apply to the out-of-pocket limit?

Are there any limits to the number of times you may receive a service (lifetime maximums or annual benefit caps)?

Questions about Customer Service

Has the company had a high number of consumer complaints?

What happens when you call the company's consumer complaint number?

How long does it take to reach a real person?

SPECIAL INSURANCE PROGRAMS

The following programs are designed to help individuals and families who wouldn't otherwise be able to purchase insurance. Healthy Montana Kids is a low-cost insurance option for eligible children. The Montana Comprehensive Health Association and the Montana Affordable Care Plan can be a last resort for individuals with high-risk, pre-existing conditions.

Low-Cost Children's Health Insurance

Healthy Montana Kids (HMK)

Healthy Montana Kids offers free or low-cost coverage for qualifying children and teenagers up to age 19.

For more information call 1-877-543-7669 or visit www.hmk.mt.gov.

Last Resort Insurance Options

Montana Comprehensive Health Association (MCHA)

Individuals who have been denied coverage by two insurers, have had a policy issued with an exclusionary rider, or have a qualifying diagnosis can obtain coverage through the Montana Comprehensive Health Association.

For an application or more information please contact:

Montana Comprehensive Health Association
404 Fuller Ave.
P.O. Box 4309
Helena, MT 59604-4309
1-800-447-7828 ext. 2128
www.mthealth.org

Sometimes, depending on availability, premium assistance is available for low income people.

Montana Affordable Care Plan (MAC)

Individuals who have been uninsured for at least six months and who have a pre-existing condition are eligible for coverage under the MAC plan.

To apply, go to www.mthealth.org or call 1-800-447-7828, ext. 2128.

WHEN YOU HAVE A PROBLEM

Contact your agent or company

If you believe your insurance company has improperly refused to issue or renew your policy, or refused to pay part or all of a valid claim, contact your agent or company first. Many times a mistake has been made and will be corrected upon inquiry. Keep a copy of all written correspondence. If you contact your agent or company by telephone, keep a record of the date and time of the call, the name of the person you spoke with and the details of the conversation.

Contact the Office of the Commissioner of Securities and Insurance

If you do not receive a prompt, courteous and satisfactory response from your agent or company, you may want to get help to resolve your problem.

The Office of the Commissioner of Securities and Insurance *will*:

- Thoroughly investigate your complaint;
- See that you get a clear response to your questions; and
- Correct misunderstandings;

The Office of the Commissioner of Securities and Insurance *cannot*:

- Force a favorable action on your complaint if it is not supported by facts and law;
- Provide legal information that sometimes is necessary to settle complicated problems; and
- Make recommendations on policies, agents or companies;

SHOPPING TIP: The Commissioner is here to help.

If you do not receive a prompt, courteous and satisfactory response, you may need help to resolve your problem.

Contact the Commissioner's office:

1-800-332-6148 or MTHealthConsumer@mt.gov

Our professional consumer advocates are available to assist you on a wide range of insurance issues.



Understanding the CSI Consumer Complaint Process

How to file an on-line complaint

1. Click the 'File an Insurance Complaint' tab on either the CSI website Home page or the Consumer page (www.csi.mt.gov).
2. When your complaint is received, a file number will be assigned and you will be sent written notification of that number. Please refer to the complaint file number when you call or write to the Department.
3. When a response to the complaint is received from the company or producer, a Compliance Specialist will review the complaint and response. This review will result in one of the following actions:
 - ☑ If the complaint has been resolved, the complaint will be closed and you will be sent a letter;
 - ☑ If an insurance law has been violated, the Department will request corrective action;
 - ☑ If the company is not abiding by the policy, the Department will request corrective action;
 - ☑ If the insurer or producer has not responded to all questions or has not investigated the complaint thoroughly, the Department will require them to do so;
 - ☑ If no violation of Montana insurance law is found, a letter will be sent to you with an explanation of the finding and notice that the investigation is being closed;
 - ☑ In each instance, you will receive a written response from the Department explaining the results of our investigation.

Before filing a complaint

1. Contact the insurance company or agent and bring the problem to their attention. Document your phone calls by noting the name of the person you speak to, the date of the call and a brief summary of the conversation. Keep copies of all written communications.
2. If you are not satisfied with the results you receive, contact the Department of Insurance for assistance. Compliance Specialists are available to answer general questions by phone at our toll-free Consumer Assistance Hotline (800) 332-6148 or in Helena 444-2040. **Official complaints must be submitted in writing.**

What types of complaints does the Office of the Commissioner of Securities and Insurance (CSI) handle?

The CSI handles most insurance problems involving home, business, auto, health, life, etc. Those problems may include coverage issues, claim disputes, premium problems, sales misrepresentations, policy cancellations, and refunds. We also investigate complaints against insurance agents, adjusters and consultants.

Where else can I go for help?

For more help with specific issues, check the list of organizations below. They may be able to assist you, if the CSI cannot:

- If you are covered under a **Medicare, Medicare Advantage, or Medicare Part D drug plan**, contact the [Centers for Medicaid and Medicare Services](#) at 1-800-MEDICARE (1-800-633-4227.) (The CSI does handle complaints related to Medicare Supplement Insurance.)
- If your complaint involves a **workers' compensation claim**, contact the Workers' Compensation Claims Assistance Bureau (406) 444-1574.
- If your complaint involves a **federal health or life insurance plan**, contact the [U.S. Office of Personnel Management](#) at (202) 606-1800.
- If you're insured through the **U.S. military and a Montana resident**, contact TRICARE 1-888-874-9378.
- If you bought your policy in **another state**, contact that [state's insurance commissioner's office](#).
- If you are covered by a **self-funded employer health plan**, contact the [U.S. Department of Labor](#) at 1-866-444-3272 or your employer.
- For further information go to www.healthcare.gov

The CSI cannot:

- Act as your legal representative or give you legal advice;
- Intervene in a pending lawsuit, on your behalf;
- Consult with you if you are represented by an attorney unless we have your attorney's written permission;
- Recommend an insurance company, producer or policy;
- Identify an insurance company with whom another person may have a policy;
- Resolve a dispute between you and your insurance agent or company when the only evidence is your word against the word of the producer or company;
- Make medical judgments;
- Cannot determine the value of damaged or stolen property or conclude who was at fault for an accident;
- Establish the facts surrounding a claim (such as who is being truthful when there are differing accounts of what happened);
- Address plans or companies that are not subject to the insurance laws of Montana or that are governed by other state or federal agencies. For example, we have no regulatory authority over MMIA (Montana Municipal Insurance Authority) as they are not an insurance company. Also, we do not have regulatory authority over rental car agencies as they are usually self-insured.

The CSI does not have jurisdiction over the following plans:

- State Sponsored Self-Insured Health Plan for Teachers and State Employees;
- Self-Funded Employee Health Benefit Plans. Many large employers provide health benefits for their employees through self-insured plans. Although self-insured plans are frequently administered by an insurance company, it is the employer and not the insurance company that bears the risk for paying claims;
- Federal Employees' Health Plan and Life Insurance;
- Medicare Advantage or Medicare Part D;
- Medicaid;
- Workers Compensation Claims; and
- Any self-funded governmental plans.



MONICA J. LINDEEN

COMMISSIONER OF SECURITIES & INSURANCE

MONTANA STATE AUDITOR

840 HELENA AVE., HELENA, MT 59601

Telephone (406) 444-2040/Toll Free 1-800-332-6148

www.CSI.mt.gov

INSURANCE INQUIRY/COMPLAINT FORM

Please complete this form and mail to the above address to the attention of PHS (Policy Holder Services). It may take several weeks for the Department to complete the review and take appropriate action. *You will hear from a Compliance Specialist, in writing, as soon as the review is complete.*

Your Name _____ Phone No. _____

Address _____
(Mailing Address) (City) (State) (Zip Code)

Insurance Company's Name _____

Policy No. _____ Claim No. _____

Kind of Policy: ___Auto ___Life ___Health ___Property ___Other _____

Agent's Name _____ Date of Loss: _____

.....
Please indicate which of the following is applicable:

My complaint is against: ___COMPANY ___AGENT ___ADJUSTER

1. ___ The company has unfairly rejected my claim or has not paid the full benefits to which I am entitled.
2. ___ The company has delayed processing my claim and I am unable to obtain a response from them concerning it.
3. ___ The company has not refunded premium moneys that are due to me.
4. ___ I believe the company's action of cancellation or non-renewal of my policy is not justified.
5. ___ Other _____

Do you have an attorney handling this for you? ___ If not, in your own words, describe your problem. If more space is needed, please add additional sheets. Enclose copies of papers and other correspondence relative to this problem. A copy of this form may be forwarded to the insurance company involved. By signing this form, I hereby give the Office of the Commissioner of Securities and Insurance permission to investigate this complaint on my behalf and forward it to the insurance company/agent for a formal response.

Signature _____ Date _____

INSURANCE INQUIRY/COMPLAINT FORM

[illegible]

Glossary of Terms

Annual limit (or Annual Benefit Maximum) Many health insurance plans place dollar limits upon claims for particular services that the insurer will pay over the course of a plan year (i.e. physical therapy). The ACA restricts annual limits to a certain dollar amount for essential benefits for plan years beginning after September 23, 2010. Beginning in 2014, annual limits on essential benefits are not allowed.

Affordable Care Act (ACA) The common name for the Patient Protection and Affordable Care act signed by President Obama on March 23, 2010.

Balance billing When you receive services from a health care provider that does not participate in your insurer's network, the health care provider is not obligated to accept the insurer's payment as payment in full and may bill you for the "overcharge," (i.e. the billed charge that is over and above the amount that insurance company "allowed" for the service provided.)

Broker In Montana, this individual is known as an "insurance producer," a licensed agent appointed by an insurance company who helps businesses and individuals obtain a health plan. A producer "sells, solicits and negotiates" insurance for the companies that they represent.

CHIP The Children's Health Insurance Program (CHIP) provides coverage to low and moderate income children. In Montana, this program is known as the "Healthy Montana Kids" program (HMK). Like Medicaid, it is jointly funded and administered by the states and the federal government.

COBRA Coverage COBRA provides certain former employees, retirees, spouses, former spouses and dependent children the right to temporary continuation of health coverage at group rates if the employer has 20 or more employees.

Coinsurance A percentage of a health care provider's charge (allowed by the health insurer) for which the patient is financially responsible under the terms of the policy (usually 20% to 50%).

Community Rating (adjusted) An insurance pricing method in which each policyholder or member of the same risk pool pays a premium that's not based on health status, but may be based on age or other factors like tobacco use and geographic location.

Community Rating (pure) An insurance pricing method in which each policyholder or member of a large group pays the same premium, regardless of health status, age or other factors.

Coordination of benefits If a patient has more than one health plan which covers their medical expenses, "coordination of benefits" rules divide the responsibility of payment between the health plans so that together they will pay up to 100%.

Co-payment A flat-dollar amount which a patient must pay when visiting a health care provider, as opposed to "co-insurance" which is a percentage of the provider charge.

Deductible A dollar amount that a patient must pay for health care services each year before the insurer will begin paying claims under a policy.

Defined Contribution Employer sponsored health plans that allow individual employees full control over their plan choice.

ERISA The Employee Retirement Income Security Act of 1974 is a federal law that applies to most kinds of employee benefit plans, including health care benefit plans.

Exclusionary Rider An exclusionary rider is an amendment to an insurance policy that excludes coverage for a particular illness or condition. Starting in September 2010, under the ACA, exclusionary riders cannot be applied to coverage for children. Starting in

2014, no exclusionary riders will be permitted in any health insurance.

External review An independent, medical review of an insurers' determination that a requested or provided health care service is not or was not medically necessary. Medical professionals from an "independent review organization" (IRO) with no connection to the health plan must conduct the review. ACA requires all non-grandfathered health plans to provide an external review process that meets minimum standards.

Formulary The list of drugs covered fully or in part by a health plan.

Grandfathered plan A health plan that an individual was enrolled in prior to March 23, 2010. Grandfathered plans are exempted from some changes required by ACA. New employees may be added to employer group health plans that are grandfathered, and new family members may be added to all grandfathered plans. Certain benefit changes trigger loss of grandfathered status.

Group health plan An employee welfare benefit plan that is established or maintained by an employer or by an employee organization (such as a union), or both, that provides medical care for participants or their dependents directly or through insurance, reimbursement or otherwise.

Guaranteed renewability Requires health insurers renew coverage under a health plan except in cases of failure to pay premium, intentional misrepresentation of a material fact or fraud. HIPAA requires that all health insurance be guaranteed renewable.

Health Maintenance Organization (HMO) A type of managed care organization (health plan) that requires or creates financial incentives for a covered person to use health care providers that are managed, owned or under contract with a health insurer licensed as HMO. This does include preferred provider organization health plans.

Healthy Montana Kids (HMK) An acronym for the state Children's Health Insurance Program, a state health insurance plan for children. Depending on income and family size, working Montana families who do not have other health insurance may qualify for HMK.

Health Savings Account (HSA) Individuals covered by a qualified high deductible health plan (HDHP) that applies the deductible to all benefits, including prescription drugs, can open an HSA on a tax preferred basis to save for future qualified medical and retiree health expenses.

High Deductible Health Plan (HDHP) A plan which, when compared to traditional health insurance plans, requires greater out-of-pocket spending, although premiums may be lower. In 2010, an HSA qualifying HDHP must have a deductible of at least \$1,200 for single coverage and \$2,400 for family coverage. The plan must also limit the total amount of out-of-pocket cost sharing for covered benefits each year to \$5,950 for single coverage and \$11,900 for families.

High risk pool A government-subsidized health plan that provides coverage for individuals with pre-existing health care conditions who cannot purchase it in the private market. ACA created a temporary federal high risk pool program, administered by the states, to provide coverage to individuals with pre-existing conditions who have been uninsured for at least 6 months. In Montana, this is known as the Montana Affordable Care Plan or MAC Plan.

HIPAA (Health Insurance Portability and Accountability Act of 1996) A federal law making it easier for individuals to move from job to job without the risk of being unable to obtain health insurance or having to wait for coverage due to pre-existing medical conditions.

In-network provider A health care provider (such as a hospital or doctor) that is contracted to be part of the network for a

managed care organization (such as an HMO) or Preferred Provider Organization (PPO). The provider agrees to the rules and fee schedules in order to be part of the network and agrees not to bill patients for amounts beyond the agreed upon fee.

Individual market The market for health insurance coverage offered to individuals other than in connection with a group health plan.

Internal review An insurer’s review of its determination that a requested or provided health care service is not or was not medically necessary. This is also known as an “internal appeal” or “grievance procedure.” The ACA requires all plans, including individual health plans, to conduct an internal review upon request of the patient or the patient’s representative. Internal review rights are also required for eligibility decisions and rescission decisions.

Job Lock A situation where individuals remain in their current job because they have an illness or condition that may make them unable to obtain individual health insurance coverage if they leave that job.

Lifetime limit Many health insurance plans place dollar limits upon the claims that the insurer will pay over the course of an individual’s life. Since September 23, 2010, ACA prohibits lifetime limits on essential benefits on all health plans.

Limited Benefits Plan A type of health plan that provides coverage for only certain specified health care services or treatments or provides coverage for health care services or treatments up to a certain dollar amount during a specified period.

Mandated benefit A requirement in state or federal law that all health insurance policies provide coverage for a specific health service, such as maternity or mental health care.

Medicaid A joint state and federal program that provides health care coverage

to eligible categories of low income individuals.

Medicare A federal government program that provides health care coverage for all eligible individuals age 65 or older or under age 65 with a disability, regardless of income or assets. Eligible individuals can receive coverage for hospital services (*Medicare Part A*), medical services (*Medicare Part B*), and prescription drugs (*Medicare Part D*).

Medicare Advantage *Also known as Medicare Part C.* An option where Medicare beneficiaries can choose to receive most, or all, of their Medicare benefits through a private insurance company. Plans contract with the federal government and are required to offer at least the same benefits as original Medicare, but may follow different rules and may offer additional benefits. Unlike original Medicare, enrollees may not be covered at any health care provider that accepts Medicare, and may be required to pay higher costs if they choose an out-of-network provider.

Medicare Supplement Insurance Private insurance policies that can be purchased to “fill-in the gaps” and pay for certain out-of-pocket expenses (like deductibles and coinsurance) not covered by original Medicare (Part A and Part B).

Open enrollment period A specified period during which individuals may enroll in a health insurance plan each year. In certain situations, such as if one has had a birth, marriage, death or divorce in their family, or other loss of coverage event, individuals may be allowed to enroll in a plan outside of the open enrollment period.

Out-of-network provider A health care provider (such as a hospital or doctor) that is not contracted to be part of a health insurer’s network (such as an HMO or PPO). Depending on the insurer’s rules, an individual may not be covered at all or may be required to pay a higher portion of the total costs when he/she seeks care from an out-of-network provider.

Out-of-pocket limit An annual limitation on cost sharing for which patients are responsible under a health insurance plan. This limit does not apply to premiums, balance-billed charges from out of network health care providers or services that are not covered by the plan.

PHS Policyholder Services, a division of the Montana Office of the Commissioner of Securities and Insurance, which handles insurance consumer complaints and appeals.

Portability Coverage HIPPA guarantees individual coverage for people leaving employer-sponsored group, church or government plans if you have had continuous coverage during the previous 18 months through any combination of plans.

Pre-existing condition exclusion The period of time that an individual receives no benefits under a health benefit plan for an illness or medical condition for which an individual received medical advice, diagnosis, care or treatment within a specified period of time prior to the date of enrollment in the health benefit plan.

Premium The periodic payment required to keep a policy in force.

Preferred Provider Organization (PPO) A type of health plan that provides health care coverage through a network of providers. Typically the PPO requires the policyholder to pay higher costs when they seek care from an out-of-network provider. A PPO is not an HMO and cannot have a “closed” plan, whereby a covered person may ONLY receive care from a predetermined panel of providers. Some level of coverage for out-of-network providers must be provided.

Preventive benefits Covered services that are intended to prevent disease or to identify disease while it is more easily treatable. ACA requires insurers to provide coverage for certain preventive benefits without cost sharing in non-grandfathered health plans.

Public Small Employer A city, town, county, or school district or an educational cooperative with fewer than 50 employees.

Reinsurance Insurance purchased by insurers from other insurers or sometimes provided by a government source to limit the total loss an insurer would experience in the case of very high claims. ACA directs states, with the assistance of HHS, to create temporary reinsurance programs to stabilize their individual markets during the implementation of health insurance reform.

Rescission The process of voiding a health plan from its inception based on the grounds of fraud or intentional material misrepresentation on the application for insurance coverage that would have resulted in a different decision by the health insurer with respect to issuing coverage. ACA prohibits rescissions, except in cases of fraud or intentional misrepresentation of a material fact.

Self-insured Group health plans may be self-insured or fully insured. A plan is self-insured (or self-funded), when the employer assumes the financial risk for providing health care benefits to its employees. A plan is fully insured when all benefits are guaranteed under a contract of insurance that transfers that risk to an insurer.

Solvency The ability of a health insurance plan to meet all of its financial obligations. State insurance regulators carefully monitor the solvency of all health insurance plans and require corrective action if a plan’s financial situation becomes hazardous. In extreme circumstances, a state may seize control of a plan that is in danger of insolvency.

Waiting period A period of time that an individual must wait, either after becoming employed or submitting an application for a health insurance plan, before coverage begins.

CONTACT Us

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The Office of the Commissioner of Securities and Insurance, Montana State Auditor, is a criminal justice agency whose primary mission is to protect Montana's consumers through securities and insurance regulation. We work hard everyday to educate and assist the public about the wide range of issues in insurance and securities. We are committed to ensuring fairness, transparency and access in the securities and insurance industries.



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